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Non-Profit Hospitals Face Structural As Well As Financial Challenges: Lessons from Massachusetts

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Abstract:

Like most non-profit hospitals, those of Massachusetts are facing serious financial challenges. While the immediate issue is the shortfall between revenues and expenses, the paper finds that their real problems are structural, evidenced by at least three systemic impediments - uncompensated care, over-utilization of teaching hospitals, and an increasingly unattractive environment for the practice of medicine. Other states whose non-profit hospitals face persistent financial difficulties may find it useful to consider whether structural impediments of the type facing Massachusetts undermine the operating performance of their own institutions.

Introduction:

The rating agencies remind us that the outlook for the nation's non-profit hospitals is at best problematic. (1, p.3; 2, p.1) The culprits include: weak patient volume; declining governmental and non-governmental reimbursements; mounting expenses, especially labor and growing bad debt costs (the latter reflecting the push toward consumer-driven care); increases in the uninsured population; competition from physician-owned diagnostic and treatment centers; and accumulating unfunded capital needs. This portends increasingly difficult access to credit markets at a time of significant capital needs. (3, p.1)

This paper examines one portion of the non-profit hospital universe, that of Massachusetts hospitals. Despite its long-held reputation as a Medical Mecca, the state's predominantly non-profit health care system has faced what one observer calls a perpetual "cycle of fiscal convulsions." (4, p.1) As explored below, the financial performance of its acute hospitals has been marginal at best for many years, with one-third of them having closed over the

past 25 years. One survey reports that nearly 60 percent of the responding hospitals had delayed capital investment in order to first address their respective operating shortfalls. (5, p.3) And an analysis of hospital access to capital ranks Massachusetts fifth worst out of fifty states. (6, pp.5-9)

The on-going financial challenges facing the state's hospitals prompted the former head of one of Boston's teaching hospitals to predict that "there are elements both formed and gathering that will create the 'perfect storm' that will devastate Massachusetts hospitals." (7, p.16) This study was undertaken to test veracity of that prediction. As the research evolved, it became increasingly clear that, while the immediate challenges of the typical Massachusetts hospital is the class mismatch between revenue and expenses, the real problems are structural in nature. The question for other state systems is whether the operating performance of their non-profit hospitals is also being undermined by (similar or different) structural impediments.

The Massachusetts Health Care Setting:

The condition of Massachusetts hospitals is an outgrowth of the state's unique health care setting. This includes its over-whelming bias against for-profit health care, a bias stemming from a widely held view that, as a consumer entitlement, health care can be easily compromised in a for-profit setting focused on net income rather than quality of care for everyone, including the uninsured. Reflecting this strong non-profit bias, 97 percent of the state's hospitals are non-profit (compared to 85 percent nation-wide) while non-profit HMOs account for well over 90% of all managed care enrollments (versus 35 percent nation-wide).

Another feature of Massachusetts health care dates from 1991, when the long-standing hospital rate setting system (guaranteeing fixed payments regardless of cost) was abolished. The

objective was to force hospitals to negotiate separately with each private payer, presumably helping to contain health case costs. Hospitals were henceforth expected to compete on the basis of pricing, which would in turn depend on each institution's respective costs and reimbursement arrangements.

There were two significant outcomes of the new Darwinian environment. First was the dramatic drop in the excess hospital capacity that had accumulated during the nearly two decades (prior to 1991) of state-mandated hospital fees. Accordingly, in the decade that followed (i.e., 1991- 2001), the number of hospitals fell 20.8 percent (vs. the national average of 8.1 percent); beds decreased by 23.8 percent (vs. 10.6 percent), inpatient days dropped 24.1 percent (vs. 12.9 percent); and outpatient visits increased 76.4 percent (vs. 67.2 percent). (8, p.132)

Second, competition also led to consolidation in the payer market, as cost-conscious employers turned to managed care payers to contain rising health care premiums. In the increasingly cut-throat quest among HMOs for market share, only four major health plans ultimately prevailed; all are local (as opposed to national) and currently control some 85 percent of the state's private health insurance market. The dominance of these plans within the state reflects the particular nature of the Massachusetts HMO market, where providers contract with multiple HMOs, all of which generously accommodate enrollee and physician preferences in the selection of hospitals, specialists, procedures, and tests.

As the local HMO market matured in the 1990's, competition for market share among the state's HMOs resulted in aggressive under-pricing of premiums. The other component of the HMOs' strategy was to contain provider reimbursements by pitting hospital against hospital, curtailing the use of more expensive inpatient care, and keeping payment-to-cost ratios well below hospital break-even levels. The rising popularity of HMOs among employers compelled

hospitals to accept reimbursement discounts or lose patients to more accommodating competitors. As will be discussed later, the HMO oligopoly also significantly restricted physician reimbursement.

Until the late 1990's, hospitals managed to offset low Medicaid and HMO reimbursements with generous Medicare payments, often running at rates of at least 15 percent above treatment cost. But this windfall ended with passage of the federal Balanced Budget Act (BBA) of 1997, which drastically reduced Medicare payments to acute care hospitals, home health care providers, and nursing homes across the nation. The impact was especially severe in Massachusetts, where Medicare accounts for one-third of hospital reimbursements.

Besides losing money to Medicare, the state's hospitals have also historically been underpaid by both Medicaid (accounting for about one-tenth of total hospital revenues) and managed care providers (one-third of revenues). The pernicious impact of Medicaid will be discussed later. In a bold effort to break the strangle-hold that managed care has had on hospital revenues, the state's dominant hospital system, Partners HealthCare, told each of its three major private payers in 2001 that, without "full-cost pricing," its hospitals were prepared to withdraw from recalcitrant provider networks. Partners was emboldened by the market power it had acquired through the dramatic shrinkage of hospital capacity occurring over a decade-plus of managed care underpayments and state-wide hospital closures. The upshot was that Partners successfully negotiated major hikes in their payment-to-cost ratios that heralded a new era in Massachusetts HMO reimbursements. Other hospitals have followed suit but, lacking Partners' leverage, typically with less success, meaning lower increases.

Hospital Financial Performance:

Over the past 50-plus years, Massachusetts hospital total margins have consistently lagged the national average. (9, p.17) In the 1970's and 1980's, Massachusetts hospitals' low margins were due mainly to the hospital rate setting environment previously referenced. In the 1990's, the cause was tight-fisted reimbursement by governmental and non-governmental payers. Improved managed care payments since 2001 have allowed some hospitals occasionally to break out of their loss modes and report bounces in earnings. But these blips are relatively rare, typically followed by a reversion to red ink.

The following tables document the persistent underperformance of Massachusetts acute care hospitals vis-a-vis their national peers. While data for FY2004 are an improvement against historic numbers (reflecting higher private payer reimbursements), the overall trend remains troubling for a variety of reasons, including: the operating margin of half of the state's hospitals is lower than the minimally positive 0.8 percent median; 42 percent of hospitals reported negative operating margins in FY 2004, with

Table 1: Massachusetts Hospital Median Margins: 1998-2004

	1998	1999	2000	2001	2002	2003	2004
Operating Margins:	-1.2%	-1.1%	-1.0%	-0.6%	0.1%	0.1%	0.8%
Total Margins:	2.0%	1.2%	1.0%	0.8%	0.4%	1.0%	1.8%

Source: Massachusetts Hospital Association, "Report on Acute Care Hospital Performance," February 11, 2005. Data derived from 1998-2003 hospital-submitted Schedule 23, Form 403 Cost Reports, collected by the Massachusetts Division of Health Care and Finance Policy (DHCFP); and MHA Survey (FY2004)

Table 2: U.S. Hospital Median Total Margins: 1998-2003

1998	1999	2000	2001	2002	2003
3.8%	3.4%	3.0%	3.1%	4.0%	2.7%

Source: Massachusetts Hospital Association, "Report on Acute Care Hospital Performance," February 11, 2005. Data derived from CHIPS/Ingenix (2003 results are preliminary).

over one-third reporting worse results than the prior year; and 25 percent of hospitals reported negative total margins, with one-third experiencing a deterioration from the year before. In short, the seven year average (1.17 percent) is not only well below the national average (3.33 percent) but also well below the 3 percent margin generally required for long-term viability. (10, p.1)

Clearly the financial quagmire in which the state's hospitals find themselves is not a one-time phenomenon. The question thus becomes: do these consistently poor financial results stem from factors other than the obvious gap between revenues and expenses? The remainder of this paper argues that least three structural factors underlie the on-going financial problems of the state's hospitals.

Uncompensated Care:

Medicaid, the federal health care program for the low income and disabled that is administered at the state level, has been a generous provider of health care benefits to Massachusetts residents. Enrollment has grown to one million (up from 700,000 in 1997) out of a total population of six million. But Medicaid has never been popular with the state's hospitals since it reimburses them an average of 70 cents per each dollar's worth of inpatient and outpatient care, one of the lowest Medicaid rates in the nation.

Even more problematic for the hospitals, however, is the significant increase within Massachusetts of the number of people without health care insurance (from 365,000 four years ago to an estimated 600,000 in 2004), reflecting a combination of rising unemployment, reduced small business health care coverage, and Medicaid eligibility cutbacks. The burden of caring for

this growing uninsured population has fallen primarily on the hospitals through the Uncompensated Care Pool ("UCP"), which was created in 1985.

Prior to the UCP, hospitals could pass the cost of treating uninsured patients onto privately insured patients. But inner city hospitals, the major providers of uncompensated care, were at a relative disadvantage, given their relatively smaller volumes of privately insured patients compared to the typical suburban hospital. The UCP was thus created to reimburse hospitals and freestanding community health centers for uncompensated care to low-income state residents as well as urgent care to non-residents.

What began as a sound theoretical concept based on social equity has become a major source of divisiveness within the state's hospital universe. At the outset, fearing a dramatic increase in uncompensated care costs, the private payers negotiated a cap for which they would be responsible each year. Costs above that cap are funded by annual contributions from the government and the hospital industry. All hospitals contribute to the pool, with those treating the highest percentage of privately insured patients paying the most. Provider hospitals are paid from the pool, with those treating the largest number of poor patients receiving the most. To minimize abuses, audits were officially mandated to ensure that hospitals serving the uninsured were not writing-off as "bad debt" or "free care" those accounts that could in fact be reasonably collected from insured patients.

Two decades later, with annual payments from the UCP running in the $500 million range, the pool has grown into an unwieldy system with little accountability and considerable inconsistency with regard to coverage and payment. For example, the UCP covers emergency services in some places but elsewhere acts like a comprehensive health program, providing primary and routine care. There is similar disparity in terms of reimbursement, with some

institutions being paid for as much as 95 percent of free care cost (versus 70 percent under Medicaid) while others receive less than half their costs. A major problem has been different payments for the same procedure; e.g., a routine appendectomy is reimbursed at some urban hospitals at a rate more than double what a suburban hospital receives.

Because the largest proportion of the uninsured live in urban areas, the urban hospitals - including the teaching hospitals- are the major UPC recipients. The two major "safety net" hospitals (Boston Medical Center and Cambridge Health Alliance) receive the bulk of pool dollars. Since allowable uncompensated care costs typically exceed available pool funds each year, all other hospitals effectively fund any shortfall by paying higher yearly assessments into the UCP. The net effect is that more than half (some $250 million) of all uncompensated care in the state is being paid for by the hospitals. As the size of the uninsured community grows, the financial burden on the hospitals is further exacerbated. Particularly disadvantaged are community hospitals, not only because they are reimbursed at below cost but also, and more significantly, because they have ended up paying most of the hospital component of UCP funding. For example, one typical 150-bed community hospital, with annual revenues of $200 million, pays between $3-4 million as its contribution to the pool, effectively eroding its entire operating surplus (and, in the process, most of its capital budget).

While few would dispute the UCP's vital role in funding care to the uninsured, the real issue is who should be underwriting that care -the state or the local hospitals that are being forced to redirect millions of health care dollars annually from their primary missions of providing health care to their neighboring communities.

Over-Utilization of Teaching Hospitals:

An ongoing debate within the state's health care community is the relative quality and cost of care provided by teaching versus community hospitals. A recent study of data from hospitals in six states, including Massachusetts, finds that: 1) inpatient cost per case is19 percent greater at teaching hospitals than it is at community hospitals; and 2) the quality of care provided by community hospitals is comparable to that at teaching hospitals. (11)

These findings notwithstanding, Massachusetts residents have a strong bias in favor of using teaching hospitals for even the most common procedures. The result is that health care costs in the state are immeasurably increased by the overuse of the higher cost providers. This, in turn, has distorted hospital utilization and produced severe capacity constraints. A report on health care outcomes notes:

> National data show that Massachusetts residents are hospitalized in teaching hospitals three times more often per 1,000 population than residents of other states who rely more heavily on community hospitals. Care for comparable conditions is typically more expensive at teaching hospitals than at community hospitals due to overhead expenses inherent in teaching and research functions, and the availability of advanced technology and equipment. In addition, dependence on teaching hospitals in Massachusetts is increasing, and younger patients are migrating to teaching hospitals more rapidly than older patients. (12, p.1)

Illustrating the point by citing state-wide maternity outcomes, the same study noted that over a recent 2-year period, two-thirds of the women delivering in Boston's six (of the state's eight) teaching hospitals resided in ZIP codes outside the city's limits. Another recent study notes that the teaching hospitals operate at bed-occupancy rates ranging from 85% to 100%, compared to 60% among the state's community hospitals. (13, p.3) The net effect has been serious erosion of community hospital revenues. And a major consequence is that, of the 29 hospitals forced to close since 1980, all were community hospitals.

The latest hospital in Massachusetts to close was the century old, 200-bed Waltham Hospital whose serving area included ten communities. Its shutdown in May, 2003, following loses in nine out of ten years, is illustrative of the teaching versus community hospital quagmire. Located within ten miles of downtown Boston, Waltham's problem was fundamental to most community hospitals in the greater Boston metropolitan area: failure to attract sufficient patients to generate adequate revenue to keep the facility open. The numbers speak for themselves: when residents of Waltham (population 58,000) needed to be admitted to a hospital, less than 40% of them chose the local community hospital. The majority did what most Massachusetts suburbanites do: they went to a teaching hospital, usually one in downtown Boston. (14, p.1)

The second-class status of the community hospitals is not only evidenced in reduced lower patient volumes. They also lack the teaching hospitals' collective access to capital (via fund raising and capital market access) as well as endowment income, their clout to negotiate higher private payer reimbursement rates (made possible by consolidations and affiliations that have concentrated patient volumes in a smaller number of providers), their access to federal research dollars, and their financial resources to compete in the crucial labor markets (nursing, pharmacists, and lab techs).

An Increasingly Unattractive Place to Practice Medicine:

Over each of the past three years, the Massachusetts Medical Society has conducted a comprehensive survey of physician practice conditions and physician attitudes toward their profession, a survey that poignantly demonstrates a third structural factor impacting the state's troubled health care system, namely the growing perception among physicians that the state is a financially and administratively difficult place in which to practice medicine. (15) The findings

of the three surveys support one another and, as the most recent one observes, the physician labor-market in Massachusetts is in what it calls a "state of crisis:"

> The physician labor market in Massachusetts continues to be under extreme stress, and the forces that pushed these markets into this unenviable state are numerous and not likely to be easily reversed. …The most significant characteristic of the…survey[s] was the extraordinarily high frequency of negative responses to all questions relating to the current availability of physicians to fill positions, as well as the degree of difficulty in recruiting and retaining physicians. In all three years, the mean response …indicate[s] that there are persistent structural problems in the functioning of physician labor markets [within the state].

More than half of the most recent respondents are dissatisfied with the current practice environment, and as many say they are not sure whether they would choose medicine as a profession again. Three-quarters call their incomes "uncompetitive," and one-quarter are contemplating a career change because of the state's practice environment. Nearly one-third have either decided to move out of the state to practice medicine or would consider doing so if the environment does not change.

What are the major factors contributing to the state's self-image as an increasingly inhospitable environment for physician practice? The recurring themes are all structural and largely unique to Massachusetts: high living costs; high practice costs; and low reimbursements. Illustratively, metropolitan Boston's cost of living is more than 35 percent above the national average of all metropolitan areas. (16) Besides high rents and salary costs for maintaining office space, the major item impacting the second factor (higher practice costs) is soaring malpractice insurance. While this is not unique to Massachusetts, it is nevertheless an especially virulent problem within the state, where the average premium charged by the largest commercial malpractice insurer jumped 77.8 percent on a compound basis from 1998 to 2003. (17) Finally, the third factor (low reimbursement rates) is exacerbated by the HMO oligopoly, blamed by

physicians as having disproportionate power to limit reimbursements and, thus, constrain physician salaries at levels considered to be among the lowest in the nation. (18)

In response to rising dissatisfaction with their work environment and compensation, the physicians choosing to remain in the system have become increasingly entrepreneurial -buying diagnostic equipment to offer patients tests ranging from magnetic resonance imaging (MRI) to nuclear radiology to stress testing previously done at hospitals; opening ambulatory surgery and orthopedic centers; and consolidating practices in order to reduce overhead and maximize the efficient utilization of equipment and treatment centers. While they may have been less aggressive than their colleagues nationally in adopting these types of money-making activities (19), the outcome will certainly be harmful to the financial health of the state's hospitals.

Conclusion:

Massachusetts hospitals face the same mismatch between revenues and expenses impacting the financial viability of non-profit hospitals across the nation. But this research has also found that the state face its own unique structural issues impacting hospital performance: an uncompensated health care system that forces hospitals to assume the charity role of the state; community hospitals that are losing market share and financial resources to the state's renowned teaching hospitals; and a work environment that undermines physician loyalty to the state and its hospitals and fosters entrepreneurial pursuits that further erode the financial strength of those hospitals. The result of these structural fissures is a hospital system whose financial performance ranks well below national averages and which, if allowed to continue, jeopardizes the state's long-held position as a Medical Mecca.

Other states whose non-profit hospitals face persistent financial difficulties might find it helpful to consider whether structural impediments -rather than more traditional accounting measures like revenues and expenses -may also be undermining the operating performance of their own institutions.

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